## The Maternal, Infant, and Early Childhood Home Visiting Program

*Partnering with Parents to Help Children Succeed*

### Background

Congress created the Maternal, Infant, and Early Childhood Home Visiting Program (Federal Home Visiting Program) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. The Federal Home Visiting Program builds upon decades of scientific research showing that home visits by a nurse, social worker, early childhood educator, or other trained professional during pregnancy and in the first years of a child's life improves the lives of children and families by preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness.[1] Research also shows that evidence-based home visiting can provide a positive return on investment to society through savings in public expenditures on emergency room visits, child protective services, special education, as well as increased tax revenues from parents' earnings.[2,3]

The Federal Home Visiting Program is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). States, territories, and tribal entities receive funding through the Federal Home Visiting Program, and have the flexibility to tailor the program to serve the specific needs of their communities. By law, state and territory grantees must spend the majority of their Federal Home Visiting Program grants to implement evidence-based home visiting models, with up to 25 percent of funding available to implement promising approaches that will undergo rigorous evaluation. For fiscal year (FY) 2016, there are 17 models that have met the rigorous criteria for evidence of effectiveness and are eligible for state/territory Program funding. In addition, five state grantees are implementing six different promising approaches, which are undergoing rigorous evaluation.

While there is some variation across evidence-based home visiting models (e.g., some programs serve expecting mothers while others serve families after the birth of a child), all programs share some common characteristics. In these voluntary programs, trained professionals meet regularly with expectant parents or families with young children in their homes, building strong, positive relationships with families who want and need support. Home visitors evaluate the families' needs and provide services tailored to those needs, such as:

- Teaching parenting skills and modeling effective techniques.
- Promoting early learning in the home with an emphasis on positive interactions between parents and children and the creation of a language-rich environment that stimulates early language development.
- Providing information and guidance on a wide range of topics including breastfeeding, safe sleep position, injury prevention, and nutrition.
- Conducting screenings and providing referrals to address postpartum depression, substance abuse, and family violence.
- Screening children for developmental delays and facilitating early diagnosis and intervention for autism and other developmental disabilities.
- Connecting families to other services and resources as appropriate.

Evidence-based home visiting programs help children and families get off to a better, healthier start.

## Expanding to Serve More Families and Communities

In FY 2015, states reported serving approximately 145,500 parents and children in 825 counties in all 50 states, the District of Columbia, and five territories through the Federal Home Visiting Program (Figure 1). Nearly 68,000 (47 percent) of those participating were new enrollees. The reported number of children and parents served has quadrupled since FY 2012, and the number of home visits provided has increased five-fold, with more than 2.3 million home visits provided over the past four years (Figure 2).

### Continued Growth in the Federal Home Visiting Program

**Figure 1: Number of Children and Parents Served by State and Territory Grantees (2012-2015)**

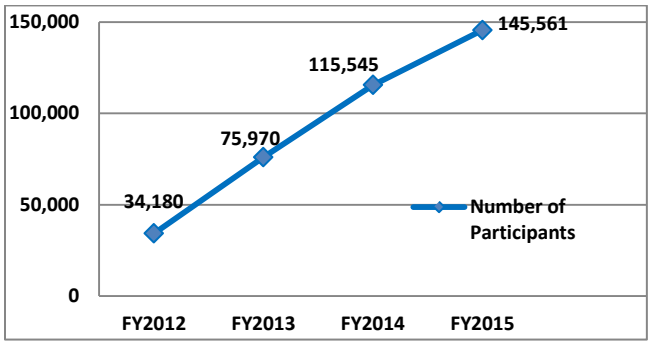
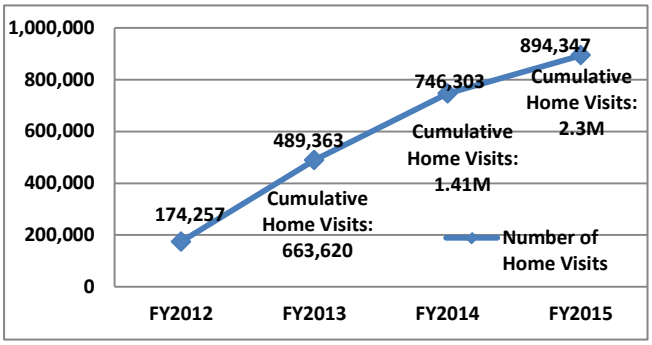



**Figure 2: Number of Home Visits by State and Territory Grantees (2012-2015)**




States have also extended the reach of the Federal Home Visiting Program into more communities:

- The total number of counties being served by the Federal Home Visiting Program has more than doubled since the start of the program, reaching families in 825 counties in FY 2015, which represent 26 percent of all U.S. counties.
- In FY 2015, the Federal Home Visiting Program funded services in 29 percent of all urban counties, and 23 percent of all rural counties.

In order to effectively expand high-quality, evidence-based home visiting programs, many grantees spent the first two years of the program focusing much of their efforts on building infrastructure (e.g., establishing referral and data systems, conducting outreach to families, and recruiting and training a highly skilled home visiting workforce).

## Program Participants

The Federal Home Visiting Program serves many of the most vulnerable families. In FY 2015:

- 77 percent of participating families had household incomes at or below 100 percent of the Federal Poverty guidelines ($24,250 for a family four), and 46 percent were at or below 50 percent of those guidelines.
- 31 percent of adult program participants had less than a high school education, and 35 percent had a high school diploma.
- Families served by the Federal Home Visiting Program were at risk for poor family and child outcomes:
    - 22 percent of newly enrolled households included pregnant teens.
    - 15 percent of newly enrolled households reported a history of child abuse and maltreatment.
    - 12 percent of newly enrolled households reported substance abuse.

In addition, 68 percent of program participants belonged to a racial/ethnic minority.

## Notable Achievements

Home visiting services are already making a meaningful difference in the lives of vulnerable children and families.[4] Some examples of this progress include:

***Developmental Delay:*** Less than 50 percent of young children with developmental or behavioral disabilities—such as autism, attention-deficit/hyperactivity disorder, or delays in language—are identified before they start school.[5] Early identification, referral and follow-up has been shown to improve the developmental trajectories of children with such delays or a developmental disability. The Federal Home Visiting Program is committed to improving the health and development of all children through developmental promotion, early identification and referral and follow-up to necessary supports and services. In 2015, 18 grantees (AK, AL, AZ, CA, CO, CT, ID, IL, LA, NE, NH, NM, NV, NY, OK, SD, TN, and UT) reported screening rates of at least 75 percent, more than twice the national average of 31 percent in 2011-2012.[6,7] For example:

- Alabama: 97 percent of enrolled children were screened for developmental delay within six months of enrollment. The state-wide screening rate was 25 percent in FYs 2011-2012.[6]
- Colorado: Nearly 95 percent of children in the Federal Home Visiting Program were screened for developmental delay. In comparison, the state-wide screening rate among children aged 10 months to five years in FYs 2011-2012 was 47 percent.[6]
- Illinois: 91 percent of enrolled children aged 12 months were screened for developmental delay. In FYs 2011-2012, the state-wide screening rate among children aged 10 months to five years was 34 percent.[6]

***Intimate Partner Violence (IPV)****:* More than one-third of women report having experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime while nearly 6 percent report experiencing IPV in the past 12 months.[8] In addition to injuries, IPV is associated with adverse physical and mental health outcomes, and exposure of children to IPV can lead to health and behavioral problems, such as anxiety and depression.[9,10,11] Despite these consequences, screening for IPV in many health care settings remains low, with only 3 percent to 41 percent of physicians reporting regularly screening for IPV.[12,13] The Federal Home Visiting program is committed to identifying risks for intimate partner violence and assuring referrals and safety planning when necessary. In FY 2015, 11 grantees (AL, AS, CA, IL, MI, NE, OH, RI, SD, VT, WY) reported screening rates of at least 95 percent. For example:

- South Dakota: 98 percent of enrolled pregnant women were screened for IPV within 36 weeks of pregnancy.
- Rhode Island: 97 percent of families were screened for IPV at enrollment.

***Maternal Depression:*** When left untreated, maternal depression has been associated with adverse birth outcomes, poor mother-child bonding, and negative parenting behaviors,[14,15,16] which can impair the development, health, and safety of young children.[17,18,19] Yet, it has been estimated that less than half of primary care physicians regularly screen for maternal depression.[20,21] The Federal Home Visiting program is committed to supporting mothers who experience depression by screening and providing support, resources and referrals as needed. In FY 2015, 12 grantees (AZ, CO, DE, IL, IN, MO, NM, NV, NY, OH, PR, WY) reported screening rates of at least 95 percent. For example:

- Arizona: 97 percent of mothers were screened for maternal depression within the first six months postpartum.
- Delaware: More than 95 percent of mothers were screened for maternal depression within the first six months postpartum.

Data from the state and territory grantees in FY 2014 showed that the overwhelming majority (83 percent) demonstrated improvement in at least four of the six benchmark areas outlined in the legislation:

- maternal and newborn health,
- child injuries, child maltreatment and emergency department visits,
- school readiness and achievement,
- crime or domestic violence,
- family economic self-sufficiency, and
- service coordination and referrals for other community resources and supports.

The nine state and territory grantees that did not demonstrate improvement received targeted technical assistance. In FY 2015, all but one of these nine grantees demonstrated improvement. Over three-quarters of the first cohort of awards to tribal entities also demonstrated improvement in four of six benchmark areas. On-going technical assistance is provided to all grantees to help support continuous quality improvements.

## Tribal Home Visiting

Since its inception, the Tribal Home Visiting Program, funded from a 3 percent set-aside from the Federal Home Visiting Program and administered by ACF, has awarded 25 grants totaling $56.3 million to tribes, consortia of tribes, tribal organizations, and urban Indian organizations to develop, implement, and evaluate home visiting programs. The program is designed to develop and strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native (AIAN) families, expand the evidence base around home visiting in tribal communities, and support and strengthen cooperation and linkages between programs that serve Native children and their families.

Due to the limited evidence base on effective home visiting in tribal communities, Tribal Home Visiting grantees may adopt home visiting models that are either evidence-based for use with AIAN populations or considered a promising approach. Model selection is designed to be a collaborative and community-driven process based community needs. Because most home visiting models selected by grantees are designed for non-Native populations, many grantees have enhanced or adapted models to fit culture and context. Adaptations and enhancements include hiring culturally competent staff from the community, incorporating traditional parenting practices, and involving cultural leaders and elders as well as model developers throughout the program development and implementation process. Tribal grantees have provided a cumulative 35,700 visits to families since FY 2012, with nearly 18,000 of those in FY 2015. Grantees served 1,800 adult enrollees in FY 2015 (up 25 percent from FY 2014 and 900 percent from FY 2012) and 1,726 index children (up 27 percent from FY 2014 and 960 percent from FY 2012). For more information on the Tribal Home Visiting Program visit http://www.acf.hhs.gov/programs/ecd/home-visiting/tribal-home-visiting.

## Research and Evaluation

ACF, in collaboration with HRSA, is overseeing the Mother and Infant Home Visiting Program Evaluation (MIHOPE), a large-scale, random assignment evaluation of the effectiveness of the Federal Home Visiting Program. Using scientifically rigorous research methods, MIHOPE will estimate the effects of home visiting on a wide range of outcomes, study the variation in how programs are implemented, and conduct a cost analysis. In addition, MIHOPE will examine what components of home visiting programs work, for whom, and why, to provide all programs and models with information they can use to promote even greater positive outcomes for families. Study enrollment and data collection began in October 2012 and concluded in September 2015. MIHOPE includes 4,229 families in 87 local home visiting program sites across 12 states.

In February 2015, HHS delivered the first in a series of MIHOPE reports to Congress. This report presents the first findings from the study, and includes an analysis of the states' needs assessments, as well as baseline characteristics of families, staff, local programs, and models participating in the study.

The report found that local programs' infrastructure is aligned with Federal Home Visiting Program expectations and designed to support quality service delivery for these families. Specific findings include:

- Home visitors are well trained, especially in child development and parenting support, with most home visitors reporting that they are trained to help families across the full range of outcome areas specified in legislation.
- 66 percent of local programs have formal referral agreements.
- 73 percent have expert consultants available.
- 84 percent had some continuous quality improvement activities in past year.

In addition, the report found that, prior to creation of the Federal Home Visiting Program, home visiting programs were an important resource throughout the country, but many communities did not use evidence-based models or had unmet home visiting needs. In response, states planned to spend Federal Home Visiting Program funds in communities that, compared with states' overall averages, had higher rates of poverty, poor birth outcomes, and child maltreatment. States' plans also pointed to an increase in use of evidence-based models, with funds used to support a combination of national models with evidence of effectiveness. Final reports on impacts, and implementation and cost effectiveness will be available in 2018.

For more information on the Federal Home Visiting Program, visit www.mchb.hrsa.gov/programs/homevisiting.

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1 U.S. Department of Health and Human Services, Administration for Children and Families, Home Visiting Evidence of Effectiveness (HomVEE). Available at: http://homvee.acf.hhs.gov/.

2 Karoly, L, et al. (2005). Early Childhood Interventions: Proven Results, Future Promise. RAND Corporation. Santa Monica, California. Available at: http://www.rand.org/pubs/monographs/MG341.html

3 Washington State Institute of Public Policy. Benefit-Cost Results. Available at: http://www.wsipp.wa.gov/BenefitCost

4 The 56 Home Visiting Program grantees measure some aspect of screening for developmental delays, intimate partner violence, maternal depression and whether children receive well-child care. Since grantees have the flexibility to develop performance measures that are meaningful to their specific programs and local community needs, the benchmarks are measured in a number of ways.

5 Mackrides PS1, Ryherd SJ. (2011). Screening for developmental delay. Am Fam Physician. 84(5):544-9.

6 Child and Adolescent Health Measurement Initiative. Data Resource Center. Available at: http://www.childhealthdata.org. (Accessed January 7, 2016).

7 American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental and Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs. (2006). Identifying Infants and Young Children with Developmental Disorder in the Medical Home: An Algorithm for Developmental Surveillance and Screening. [Published correction appears in Pediatrics. 2006;118(4):1808–1809]. Pediatrics. 118(1): 405–420

8 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). National Intimate Partner and Sexual Violence Survey: 2010 Summary Report. Available at: http://www.cdc.gov/violenceprevention/nisvs/summary_reports.html. (Accessed January 7, 2016).

9 Lamers-Winkelman, F, et al. (2012). Children's Physical Health Complaints After Exposure to Intimate Partner Violence. British Journal of Health Psychology. 17(4): 771-84.

10 Yates, T, et. al. (2003). Exposure to Partner Violence and Child Behavior Problems: A Prospective Study Controlling for Child Physical Abuse and Neglect, Child Cognitive Ability, Socioeconomic Status and Life Stress. Development and Psychopathology. 15(1): 199-218.

11 Russell, D, et. al. (2010). Witnessing Domestic Violence in Childhood as An Independent Risk Factor for Depressive Symptoms in Young Adulthood. Child Abuse and Neglect. 34(6): 448-453.

12 De Boinville, M. (2013) ASPE Policy Brief: Screening for Domestic Violence in Health Care Settings. Available: http://aspe.hhs.gov/hsp/13/dv/pb_screeningdomestic.cfm (Accessed January 7, 2016).

13 Stayton, C, and Duncan, M. (2005). Mutable Influences on Intimate Partner Abuse in Health Care Settings: A Synthesis of the Literature. Trauma, Violence, and Abuse. 2005 Oct;6(4):271-85.

14 Field, T. (2010). Postpartum Depression Effects on Early Interactions, Parenting, and Safety Practices: A Review. Journal of Infant Behavioral Development. 33: 1–6.

15 Paulson, J, et. al. (2006). Individual and Combined Effects of Postpartum Depression in Mothers and Fathers on Parenting Behavior. Pediatrics. 118(2): 659- 668.

16 Henderson, J, et. al. (2003). Impact of Postnatal Depression on Breastfeeding Duration. Birth. 30(3): 175-180.

17 Whitaker, R, et. al. (2006). Maternal Mental Health, Substance Use, and Domestic Violence in the Year after Delivery and Subsequent Behavior Problems in Children at Age Three Years. Archives of General Psychiatry. 63(5): 551-560.

18 Kavanaugh, M, et. al. (2006). Maternal Depressive Symptoms Are Adversely Associated with Prevention Practices and Parenting Behaviors for Preschool Children. Ambulatory Pediatrics. 6(1): 32-37.

19 Sills, M, et. al. (2007). Association between Parental Depression and Children's Health Care Use. Pediatrics. 119(4): 829-836.

20 Seehusen, L, et.al (2005). Are Family Physicians Appropriately Screening for Postpartum Depression? Journal of the American Board of Family Practice. 18: 104–112.

21 LaRocco-Cockburn A, et. al. (2003). Depression Screening Attitudes and Practices Among Obstetrician-Gynecologists. Obstetrics & Gynecology. 101: 892-8.